

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04798

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY CHARLES	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN RURAL (HUGHESVILLE)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN RURAL (HUGHESVILLE)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) CORA (Middle) (Last) FLUEY		4. DATE OF DEATH (Month) (Day) (Year) 5 22 1951	
5. SEX FEMALE	6. COLOR OR RACE W - U.S.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH Aug 25 - 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10h. KIND OF BUSINESS OR INDUSTRY HOME	9. AGE last birthday 63 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) CHARLES COUNTY, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JARED CHINN		14. MOTHER'S MAIDEN NAME Harriet	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT AND ADDRESS (SON) HENRY GOLDSMITH; HUGHESVILLE, MD.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Arterio-sclerotic Heart Disease, Cardiac Decompensation**

INTERVAL BETWEEN ONSET AND DEATH

2 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Generalized Arterio-sclerosis****3 years**(c) **Hypertension, mild****3 years**

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19h. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **FEBRUARY, 1948**, to **MAY 22, 1951**, that I last saw the deceasedalive on **MAY 22, 1951**, and that death occurred at **5:45 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

John N. Griffin, M.D. Hughesville, Md. 5/22/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF May 25 - 51	NAME OF CEMETERY OR CREMATORY Old Fields	LOCATION (City, town, or county) Hughesville Md	(State)
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE M. L. Howard	24. FUNERAL DIRECTOR Thurmond Thym Waldorf Md	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1951
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04799

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Chas</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Halebury md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Halebury md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Norman</u> (Middle) <u>Samuel</u> (Last) <u>Berry</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>20</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>10-12-76</u>
9. AGE last birthday <u>76</u> yrs.		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Berry md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas B. Berry</u>		14. MOTHER'S MAIDEN NAME <u>Laura Parker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Alice Summerson</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion

Antecedent cause(s) (b) Generalized Arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Medical Examiner, 1951, to 5-10-51, that I last saw the deceased alive on 5-10-51, 1951, and that death occurred at 5-10-51 m., from the causes and on the date stated above.

SIGNATURE R. J. Belden (Degree or title) MD ADDRESS Halebury md DATE SIGNED 5-10-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>May 22-51</u>	DATE THEREOF <u>May 22-51</u>	NAME OF CEMETERY OR CREMATORY <u>St Paul</u>	LOCATION (City, town, or county) (State) <u>Halebury md</u>
DATE REC'D BY LOCAL REG. <u>May 21-51</u>	REGISTRAR'S SIGNATURE <u>M. C. Howard</u>	24. FUNERAL DIRECTOR <u>Summit & Ryan</u>	ADDRESS <u>Waldorf</u>

VS. A15

100105

RECEIVED
JUN 6 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04800

Reg. Dist. No. 109

1. PLACE OF DEATH COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY CHARLES	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HUGHESVILLE		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HUGHESVILLE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) CHARLES	(Middle) WORTHINGTON	(Last) DOUGLAS
4. DATE OF DEATH	(Month) 5	(Day) 25	(Year) 1951
5. SEX MALE	6. COLOR OR RACE COLORED-US.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH OCTOBER 15, 1914
9. AGE last birthday 36 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SAW MILL LABORER	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? US.		13. FATHER'S NAME PATRICK DOUGLAS	
14. MOTHER'S MAIDEN NAME CHARLOTTE BUTLER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY No. 215-14-7384		17. INFORMANT AND ADDRESS CORRINNE DOUGLAS; HUGHESVILLE, MD.	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) EXSANGUINATION Antecedent cause(s) (b) HUULSION OF ANTERIOR WALL OF LEFT CARDIAC VENTRICLE CAUSED BY PENETRATION OF PIECE OF LUMBER HURLED FROM EDGER IN SAW MILL. Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		60 SECONDS 2 MINUTES
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION NONE	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY SAW MILL	(CITY OR TOWN) HUGHESVILLE (COUNTY) CHARLES (STATE) MD.
TIME (Month) (Day) (Year) (Hour) OF INJURY 5/25/51 10:00 m.	INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? PIECE OF LUMBER HURLED FROM EDGER PENETRATED LEFT ANTERIOR CHEST BETWEEN 3RD & 4TH INTERSPACES.
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
SIGNATURE John N. Griffin, M.D.		DATE SIGNED 5/25/51
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF 5/28/51	NAME OF CEMETERY OR CREMATORY St. Marys
DATE REC'D BY LOCAL REG. 5/28/51	REGISTRAR'S SIGNATURE Julia H. Passey	24. FUNERAL DIRECTOR Hunt & Hagan, Waldorf, Md.

690307

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
MAY 31 1951
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Moore
Indian Head

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04801

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH- COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Charles</i> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Pomonkey</i>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) <i>Harrison</i>		(First) (Middle) (Last) <i>Edelin</i>		4. DATE OF DEATH <i>May 16 1957</i>		(Month) (Day) (Year)	
5. SEX <i>M</i>	6. COLOR OR RACE <i>N</i>	7. SINGLE , MARRIED , WIDOWED, DIVORCED , (Specify)	8. DATE OF BIRTH	9. AGE last birthday <i>76</i> yrs.	If under 1 year: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Primer George CO</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Harrison</i>				14. MOTHER'S MAIDEN NAME <i>Harrison</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. <i>43-737</i>		17. INFORMANT AND ADDRESS <i>Love Williams - Pomomkey md</i>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <i>Undetermined</i>							
Antecedent cause(s) (b) <i>795.5</i>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>200c</i>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify) <i>Home</i>				PLACE (Home, farm, factory, street, office bldg, etc.) OF INJURY <i>Home</i>			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>			
				HOW DID INJURY OCCUR? <i>Pomonkey</i>			
				(CITY OR TOWN) (COUNTY) (STATE) <i>Chas The.</i>			
22. I hereby certify that I attended the deceased <i>Medical Examiner's case</i> , 19....., that I last saw the deceased alive on <i>5-16</i> , 19....., and that death occurred at <i>5P</i> m. from the causes and on the date stated above.							
SIGNATURE <i>R. J. Edelin M.D.</i>				ADDRESS <i>Lat St</i>			
DATE SIGNED <i>5-16-57</i>							
23. BURIAL, CREMATION REMOVAL (Specify) <i>Removal</i>		DATE THEREOF <i>5/17/57</i>		NAME OF CEMETERY OR CREMATORY <i>Univ. Med School Balto city md</i>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <i>5-17-57</i>		REGISTRAR'S SIGNATURE <i>M. L. Moore</i>		24. FUNERAL DIRECTOR <i>Frances A. Hemslay</i>		ADDRESS <i>538 N. Biddle St</i>	

RECEIVED

JUN 6 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04802

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Faulkner</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place)		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Faulkner</u> TOWN STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u>	(Middle) <u>Daniel</u>	(Last) <u>Farrell</u>	4. DATE OF DEATH	(Month) <u>5</u> (Day) <u>7</u> (Year) <u>1951</u>
5. SEX <u>m</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 14, 1890</u>	9. AGE last birthday <u>61</u> yrs.	If under 1 year 12 hrs. Moths. Days Hours Mio.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Reef</u>		11. BIRTHPLACE (State or foreign country) <u>St. Marys Co., Md.</u>	
13. FATHER'S NAME <u>Peter Henry Farrell</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>—</u>		17. INFORMANT AND ADDRESS <u>Mrs. Mamie Farrell, Faulkner, Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral hemorrhage</u>						
Antecedent cause(s) (b) <u>Hypertension</u>						
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>—</u>						
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>5/7</u> , 19 <u>51</u> , to <u>5/7</u> , 19 <u>51</u> , that I last saw the deceased <u>dead</u> <u>5/7</u> , 19 <u>51</u> , and that death occurred at <u>2:30 P</u> m., from the causes and on the date stated above. SIGNATURE <u>Richard T. Dwyer, M.D.</u> ADDRESS <u>La Plata, Md.</u> DATE SIGNED <u>5/7/51</u>						
23. BURIAL CREMATION REMOVAL (Specify)		DATE	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	(State)
<u>Burial</u>		<u>May 9, 1951</u>	<u>Dwyer</u>		<u>Laurel, Md.</u>	
DATE REC'D BY LOCAL REG. <u>5/7/51</u>		REGISTRAR'S SIGNATURE <u>Julia H. Vasey</u>		24. FUNERAL DIRECTOR <u>Hunt & Ryan, Waldorf, Md.</u>		ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

100105

RECEIVED
MAY 9 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04803

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH- COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Benjamin</u> (Middle) <u>D.</u> (Last) <u>GROVES.</u>	4. DATE OF DEATH	(Month) <u>May</u> (Day) <u>20</u> (Year) <u>1951</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>7-13-1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - Tenant Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>86</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>James Henry Groves</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Douglas</u>	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Mrs. Ellie Saldemith, Waldorf, Md</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Coronary Thrombosis</u>		<u>2 hrs.</u>
Antecedent cause(s)	(b) <u>Senile Arteriosclerotic heart disease</u>		<u>5 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October, 1950, to 20 May, 1951, that I last saw the deceased

alive on 20 May, 1951, and that death occurred at 8:00 EST 4 m., from the causes and on the date stated above.

SIGNATURE J. Woody (Degree or title) MD ADDRESS La Plata, Md. DATE SIGNED 20 May 51.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5/23/51</u>	<u>St. Pauls</u>	<u>Waldorf Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>5/22/51</u>	<u>Julia H. Passey</u>	<u>Smith & Ryan</u>	<u>Waldorf Md</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100105

RECEIVED
MAY 24 1951
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04804

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lablata</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Newburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Nannie</u>	(Middle) <u>C.</u>	(Last) <u>Higgs</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>16</u>	(Year) <u>1951</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug. 8, 1870</u>
9. AGE last birthday <u>80</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Charles County, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Higgs</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Marshall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, oo, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>John H. Reeder, Newburg, Md</u>	
17. INFORMANT AND ADDRESS			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Gastric hemorrhage.

INTERVAL BETWEEN ONSET AND DEATH

1 hr.

Antecedent cause(s)

(b) Generalized carcinoma, gall bladder1 year.II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
OF INJURY				

22. I hereby certify that I attended the deceased from Nov, 1949, to 16 May, 1951, that I last saw the deceased alive on 16 May, 1951, and that death occurred at 1:45 A.M., from the causes and on the date stated above.

SIGNATURE

A. Wooddy

(Degree or title)

MD

ADDRESS

La Plata, Md.

DATE SIGNED

16 May 51

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5/18/51</u>	<u>Chesnut Church</u>	<u>Wayne, Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5/17/51</u>	<u>Julia H. Vasey</u>	<u>Hunt & Ryan, Waldorf, Md</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 18 1961
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04805

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH COUNTY <u>Charles Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>D.C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Benedick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>4329 Bowen Rd. S.E.</u>	
3. NAME OF DECEASED (First) <u>MARTHA</u> (Middle) <u>JANE</u> (Last) <u>Johnson</u>		4. DATE OF DEATH <u>MARCH 3 1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>3-4-1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	9. AGE last birthday <u>60</u> yrs.
13. FATHER'S NAME <u>William Bull</u>		14. MOTHER'S MAIDEN NAME <u>ELIZA OFFUT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>BRADLEY JOHNSON JR. 4029 BOWEN RD. SE. WASH.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion</u>		420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	2 & 1/2 hours
(b) <u>arteriosclerosis</u>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
SUICIDE	INJURY		(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from May 3, 1951, to May 5, 1951, that I last saw the deceased alive on May 5, 1951, and that death occurred at 4:30 A.M. m., from the causes and on the date stated above.

SIGNATURE James H. H. Peckham M.D. Aquasco, Md. ADDRESS 5/5/51

23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>5/7/51</u>	NAME OF CEMETERY OR CREMATORY <u>Washington Nat'l.</u>	LOCATION (City, town, or county) <u>Suitland, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>5-5-51</u>	REGISTRAR'S SIGNATURE <u>M. L. Moore</u>	24. FUNERAL DIRECTOR <u>W. W. Chambers Co.</u>	ADDRESS <u>517-11 45th St. S.E.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

COPY SENT TO LOCAL REGISTRAR No. *So*

DATE *5-7-51*

RECEIVED

MAY 7 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04806

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

1. PLACE OF DEATH- COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE N. Carolina COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HUGHESVILLE		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Wilson	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) 209 Hill St.	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) VERE DUKE KARNES		4. DATE OF DEATH (Month) (Day) (Year) MAY 12 1951	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH AUGUST 23, 1895
9. AGE last birthday 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TOBACCO DEALER	
11. BIRTHPLACE (State or foreign country) Milan, Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME S. B. Karnes		14. MOTHER'S MAIDEN NAME Maud Duke	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWT		16. SOCIAL SECURITY No. 238-22-6016	
17. INFORMANT AND ADDRESS Helen Karnes - 209 Hill St. Wilson, N.C.			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) ACUTE CORONARY THROMBOSIS		30 MINUTES
Antecedent cause(s) (b) 420.1 94a Disease or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

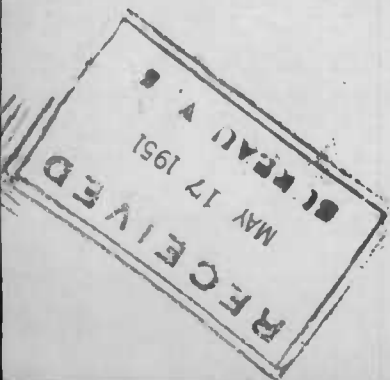
ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5/14/51	Maplewood	Wilson, N.C.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
5/14/51	Julia H. Casey	Hunt & Ryan, Waldorf Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04807

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Chas</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rock Point Md</u>		CITY (If outside corporate limits, write RURAL, and give nearest town) <u>Rock Point Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>GEORGE</u> (First) <u>A.</u> (Middle) <u>MASON</u> (Last)	4. DATE OF DEATH (Month) <u>5</u> (Day) <u>27</u> (Year) <u>1951</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>10-5-80</u> 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. Kind of Business or Industry <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>STAFFORD Co VA</u>
13. FATHER'S NAME <u>Joseph J. Mason</u>		14. MOTHER'S MAIDEN NAME <u>Sarah A. Gregory</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>5-27-51</u>	
17. INFORMANT AND ADDRESS <u>Gra. Surves</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 19, 1951 to May 28, 1951, that I last saw the deceasedalive on May 28, 1951, and that death occurred at 8 P.M. from the causes and on the date stated above.SIGNATURE E. J. E. de la(Degree or title) H.D.ADDRESS Rock Point Md.DATE SIGNED 5-28-51

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>May 31-51</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington Nat</u>	LOCATION (City, town, or county) <u>Arlington</u>	(State) <u>VA</u>
DATE REC'D BY LOCAL REG. <u>May 28-51</u>	REGISTRAR'S SIGNATURE <u>M. L. Moore</u>	24. FUNERAL DIRECTOR <u>James B. Bro</u>	ADDRESS <u>2007 Nichols Ave SE</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04808

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Ind.</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>LaPlata</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Potomac Heights</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bayview Memorial Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Ricard</u>	(Middle) <u>J.</u>	(Last) <u>Morales</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Chicano</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>14</u> (Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	8. DATE OF BIRTH <u>Feb. 2, 1908</u>	9. AGE last birthday <u>43</u> yrs. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
11. BIRTHPLACE (State or foreign country) <u>Philippines</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If year, give war or dates of service)	
16. SOCIAL SECURITY No. <u> </u>		17. INFORMANT AND ADDRESS <u>Ricard Morales, Potomac Heights Ind.</u>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Hemorrhage, internal.</u>			<u>3 min.</u>
Antecedent cause(s) (b) <u>Hypertensive Cardio-vascular disease</u>			<u>Years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Acute heart failure.</u>			<u>2 weeks.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>5-16/51</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>	LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
DATE REC'D BY LOCAL REG. <u>5-14/51</u>	REGISTRAR'S SIGNATURE <u>Julia H. Casey</u>	24. FUNERAL DIRECTOR <u>Robert A. Mattingly</u>	ADDRESS <u>Washington DC.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 17 1951
BUREAU A. I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04809

Reg. Dist. No. 105

1. PLACE OF DEATH - COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>md</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>La Plata Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore md</u>	
TOWN <u>La Plata Md</u>		TOWN <u>Baltimore md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>3326-Clark Lane</u>	
3. NAME OF DECEASED (Type or Print) <u>HAROLD</u> (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>5 24 51</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Apr 9-1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delivery store</u>	9. AGE last birthday <u>50</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore md</u>		12. CITIZENSHIP OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Charles Newman</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Newman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u>		16. SOCIAL SECURITY No. <u>Arthur Seigel</u>	
17. INFORMANT AND ADDRESS <u>Baltimore md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>CORONARY OCCLUSION</u>		<u>5-24-51</u>
Antecedent cause(s) (b) <u>420.1</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>94a</u>		

II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-24-51 to 5-24-51, 19....., that I last saw the deceased alive on 5-24-51, 19....., and that death occurred at 3:38 m., from the causes and on the date stated above.

SIGNATURE E. J. Redelen (Degree or title) M.D. ADDRESS La Plata DATE SIGNED 5-24-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/27/51</u>	NAME OF CEMETERY OR CREMATORY <u>Green Place Temple Cemetery</u>	LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
DATE REC'D BY LOCAL REG. <u>May 24-51</u>	REGISTRAR'S SIGNATURE <u>M. H. Mowbray</u>	24. FUNERAL DIRECTOR <u>Sandhein Funeral Home</u>	ADDRESS

RECEIVED

JUN 6 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04810

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Delaware</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rehoboth</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Harold</u> (Middle) <u>Leon</u> (Last) <u>PALMER</u>	4. DATE OF DEATH	(Month) <u>May</u> (Day) <u>20</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 29, 1903</u>
9. AGE last birthday <u>48</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Ref.</u>	11. BIRTHPLACE (State or foreign country) <u>Rehoboth Delaware</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>John Palmer</u>	14. MOTHER'S MAIDEN NAME <u>Mary Griffith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No. <u>no</u>	17. INFORMANT AND ADDRESS <u>Mrs. Lena Palmer, Rehoboth, Del.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion</u>			<u>3 min.</u>
Antecedent cause(s) (b) <u>Coronary insufficiency</u>			<u>2 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>940</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>20 May, 1951</u> , to <u>20 May, 1951</u> , that I last saw the deceased alive on <u>20 May, 1951</u> , and that death occurred at <u>8:07^{EST}</u> m., from the causes and on the date stated above.			
SIGNATURE <u>H. Wooddy</u> (Degree or title) <u>MD</u>		ADDRESS <u>La Plata</u> DATE SIGNED <u>20 May 51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>5/23/51</u>	NAME OF CEMETERY OR CREMATORY <u>Sunny Ridge</u>	LOCATION (City, town, or county) <u>Crisfield, Md.</u> (State)
DATE REC'D BY LOCAL REG. <u>5/22/51</u>	REGISTRAR'S SIGNATURE <u>Julius H. Casey</u>	24. FUNERAL DIRECTOR <u>Hunt & Ryan, Wallay, Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

100105

RECEIVED
JUN 4 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04811

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH: COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Waldorf MD</u> LENGTH OF STAY (in this place) <u>Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Waldorf MD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Christian Levine Proctor</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>15</u> (Year) <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Jan 15 - 51</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>4</u> yrs. If under 1 year: Months <u>4</u> Days <u>4</u> If under 24 hrs: Hours <u>4</u> Min. <u>4</u>
11. FATHER'S NAME <u>Thornton Joseph Proctor</u>		11. BIRTHPLACE (State or foreign country) <u>Tred Linn & Hagerstown, Md</u>	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		12. CITIZENSHIP <u>USA</u>	
13. SOCIAL SECURITY NO. <u>100</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Joyce Proctor</u>	
15. INFORMANT AND ADDRESS <u>Elizabeth Joyce Proctor mother</u>		16. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>5-13-51</u>	
Immediate cause (a) <u>Broncho Pneumonia</u>			
Antecedent cause(s) (b) <u>491x 107</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>10:00 PM</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/> HOW DID INJURY OCCUR? <u>Car</u>	
22. I hereby certify that I attended the deceased from <u>10:00 PM</u> to <u>11:00 PM</u> that I last saw the deceased alive on <u>5-15-51</u> , and that death occurred at <u>11:00 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>E. J. Delaney</u> (Degree or title) <u>N.D.</u>		ADDRESS <u>Latata Rd</u> DATE SIGNED <u>5-15-51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>May 15-51</u>		NAME OF CEMETERY OR CREMATORY <u>St Peter's</u> LOCATION (City, town, or county) <u>Waldorf</u> (State) <u>MD</u>	
DATE REC'D BY LOCAL REG. <u>5/15/51</u>		24. FUNERAL DIRECTOR <u>Shirley H. Hargis</u> ADDRESS <u>Waldorf MD</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

201151172404

RECEIVED
MAY 18 1951
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04812

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>La Plata</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Doncaster</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians' Memorial Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Sandra</u>	(Middle) <u>Louise</u>	(Last) <u>Skinner</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>10-28-49</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>1</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>La Plata, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter E. Skinner</u>		14. MOTHER'S MAIDEN NAME <u>Thelma L. Skinner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Walter E. Skinner, Doncaster, Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Intracranial hemorrhage</u>			<u>1 day</u>
Antecedent cause(s) (b) <u>Hydrocephalus</u>			<u>since birth</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>157a</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
HOMICIDE		INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 10-28, 1949, to 5-10, 1951, that I last saw the deceased alive on 5-11, 1951, and that death occurred at 1:00 ^{PM} m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5/13/51</u>	<u>Harlem Baptist</u>	<u>Harlem, Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5/14/51</u>	<u>Julius A. Casey</u>	<u>Hunt & Ryan, Woodrow, Md</u>		

MARGIN RESERVED FOR BINDING

VS. AT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 14 1951
BUREAU V. S.

DP